

## Reg. Dist. No.

08424

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrant prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

100

20

BUREAU V. 3

AUG 27 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(S)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08421

08425

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo, R.D.</b>		c. LENGTH OF STAY IN TB <b>all life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Conowingo</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Vernon</b> Middle <b>David</b> Last <b>ABSHER</b>				4. DATE OF DEATH Month <b>8</b> Day <b>8</b> Year <b>19 57</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 10-27-13</b>		9. AGE (in years last birthday) <b>13</b> yrs.		IF UNDER 1 YEAR Months <b>10</b> Days <b>11</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>High School</b>		11. BIRTHPLACE (State or foreign country) <b>Street, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Walter Absher</b>				14. MOTHER'S MAIDEN NAME <b>Martha Elvira Barker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>_____</b>		17. INFORMANT <b>William Walter Absher, Conowingo, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed chest and head fracture neck and fractured right clavicle</b> 9/2/1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>right clavicle</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Farm Tractor turned over on him</b>					
20c. TIME OF INJURY Month, Day, Year <b>7-15 8-8-57</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) (County) (State) <b>Conowingo Cecil Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>8-9-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery Conowingo</b>		22d. LOCATION (City, town, or county) (State) <b>Conowingo, Cecil Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Earl Tyson</b>				ADDRESS <b>Pringston Md.</b>		24a. REC'D BY REGISTRAR <b>Aug 12 57</b>	
				24b. REGISTRAR'S SIGNATURE <b>R. H. Beach</b>			

M

00

I

0

07

2

STATE OF NEW YORK  
MEDICAL EXAMINER, COUNTY OF DECATUR

1957

1957

Decatur, Ga.

Decatur, Ga.

Decatur, Ga.

Decatur, Ga.

Decatur, Ga.

Decatur, Ga.

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

BUREAU V. 2

AUG 12 1957

RECEIVED

08426

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWNSON</b>	
c. LENGTH OF STAY IN lb <b>32yrs 1mo. 7days</b>		d. STREET ADDRESS <b>31 Willow Avenue</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN (NMI) ACKERMAN</b>		4. DATE OF DEATH Month Day Year <b>August 3 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 8, 1875</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Door &amp; Sash Mfg.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>Peace Time</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records, VAH., Perry Point, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL, UNRESOLVED</b> DUE TO <b>PYELONEPHRITIS, BILATERAL, SEVERE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>491</b> DUE TO <b>PROSTATIC HYPERTROPHY, BENIGN</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 to 4 Days</b> <b>Unknown</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS, GENERALIZED</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 27, 1925</b> , to <b>August 3, 1957</b> , that cause of death was <b>as above</b> and that death occurred at <b>11: P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6 S. Ellis, M.D. V.A. Hospital, Perry Point, Md. 8-4-57</b>			
ACTUAL SIGNATURE <b>E.S. Ellis</b>			
PHYSICIAN'S NAME (Type) <b>E.S. ELLIS, M.D., Acting Director, Professional Services, VA Hospital</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>8-4-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Franklin &amp; Son</b>		ADDRESS <b>Havre DeGrace, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>8-7-57</b>
		24b. REGISTRAR'S SIGNATURE <b>James E. Dougherty</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

10-1-1937

DECEASED, NAME, RESIDENT

PREDECESSOR, NAME, RESIDENT

PROFESSION, NAME, RESIDENT

ADDRESS, NAME, RESIDENT

BUREAU V. S.

AUG 9 1937

RECEIVED

5-2-36

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08423

08416

## CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>52 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Julius</b> Middle <b>J</b> Last <b>Baer</b>				4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 15, 1882</b>		9. AGE (In years last birthday) <b>75</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Batavia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry Baer</b>				14. MOTHER'S MAIDEN NAME <b>Rosie Walcott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-22-1533</b>		17. INFORMANT <b>Union Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Corebral embolism and right hemiplegia</b> DUE TO <b>Coronary thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>7 weeks</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 10</b> , 19 <b>57</b> to <b>Aug. 31</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>August 31</b> , 19 <b>57</b> , and that death occurred at <b>5:25 P.</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>		M.D.		ADDRESS (Street, city or town, state) <b>233 E. Main Street</b>		DATE SIGNED <b>8/31/57</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b> <b>Elkton, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Beth Israel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Coatesville, Chester Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Grant</b>				ADDRESS <b>North East, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>9/2/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>JR Fraser</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

SEP 7 1957

RECEIVED



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

08424

Reg. Dist. No. 92

08417

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>3 minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Charlestown</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Louise</u> Middle <u>M</u> Last <u>Boyer</u>				4. DATE OF DEATH Month <u>8</u> Day <u>1</u> Year <u>19 57</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 -8-1915</u>		9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House Keeping</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore T Reed</u>				14. MOTHER'S MAIDEN NAME <u>Rosanna Rice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>(If yes, give war or dates of service)</u>		17. INFORMANT <u>Harvet A Boyer, Jr., Charlestown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. C. Dodson</u>				M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R. C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>8-2-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-5-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Principio Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Principio Cecil, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph P Grant North East, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>8/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>FR Frazier</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 6 1957

BUREAU V. S.

08425

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE		b. COUNTY	
Cecil				Maryland		Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Perry Point		1 yr. 2 mos.		Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Veterans Administration Hospital				Conway & Greene Streets			
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH Month Day Year		
WESLEY			CHEESEBORO		August 2 1957		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS	
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 17, 1925		32 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer					South Carolina		USA
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
David Cheeseboro			Lou Jane Bobbitt				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT Address			
Yes		Unknown		Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							INTERVAL BETWEEN ONSET AND DEATH
DUE TO							5 to 8 Mon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
(b)							
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ATHRO SCLEROSIS, GENERALIZED, MODERATELY SEVERE.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. <del>DO NOT WRITE IN THESE SPACES</del>					
		Autopsy on body only. Permission for Head refused.					
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
Hour a. p. m. 19			While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work				
21. I certify that I attended the deceased from May 17, 1956, to August 2, 1957, and that death occurred at 9:12 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE E. S. Ellis, M.D., Perry Point, Maryland 8-4-57							
PHYSICIAN'S NAME (Type) E.S. ELLS, M.D., Acting Director, Professional Services, VA Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Removal		8-4-57		Mount Vernon		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
KATIE R. WILLIAMS Funeral Home, 321-323 N. Schroeder St., Baltimore, Maryland				8-5-57 - Irene E. Lougher			

BUREAU V. S.

NOV 2 1904

RECEIVED

may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

34

08428

08428

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08426

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Richmond	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALONIDAS Middle B. Last COSTEN		4. DATE OF DEATH Month August Day 11 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-4-95
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leonidas J. Costen		14. MOTHER'S MAIDEN NAME Olivia Gertrude Cofield	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) B ronchopneumonia, bilateral, unresolved 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease, severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 3-5 days unknown
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 57	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from February 12, 19 57, to August 11, 19 57, and that death occurred at 6:25 p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 8-12-57 ACTUAL SIGNATURE William M. Harris M.D. PHYSICIAN'S NAME (Type) WILLIAM M. HARRIS Acting Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL Removal	22b. DATE THEREOF 8-12-57	22c. NAME OF CEMETERY OR CREMATORY unknown Cedar Hill	22d. LOCATION (City, town, or county) (State) unknown/ Suffolk, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE I.O. HULL & CO. FUNERAL HOME, Suffolk, Virginia. ADDRESS		24a. REC'D BY REGISTRAR DATE 8/12/57	24b. REGISTRAR'S SIGNATURE



BUREAU V. A.

1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08429

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08427

Reg. Dist. No.

92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R.D.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Old Fields Point			d. STREET ADDRESS 316 North		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Edwin Dennis Crouse			4. DATE OF DEATH Month 8 Day 18 Year 19 57		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22 1938		9. AGE (In years last birthday) 19 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Auto Parts Co.		11. BIRTHPLACE (State or foreign country) Chestertown, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Herman Lee Crouse			14. MOTHER'S MAIDEN NAME Louise Joyner		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-36-9473		17. INFORMANT Address Herman L. Crouse, 316 Nst. Elkton. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 7218 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Was in Elk River and sank in hole ah never came up.			
20c. TIME OF INJURY Month, Day, Year Hour 8-18-57		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elk River	
				20f. (City or town) (County) (State) Elkton, R.D. Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8-19-57	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-22-57	22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Mem. Pk		22d. LOCATION (City, town, or county) (State) Elkton Cecil Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph B. Hicks, Elkton, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE 8/22/57	
				24b. REGISTRAR'S SIGNATURE R. B. Trager	

BUREAU V. S.

NOV 19 1915

RECEIVED

08430

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake City</u>	
c. LENGTH OF STAY IN 1b <u>35 yrs.</u>		d. STREET ADDRESS <u>Bohemia Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bessie</u> Middle <u>Walter</u> Last <u>DeShane</u>		4. DATE OF DEATH Month <u>8</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5<sup>th</sup> 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Price Walters</u>		14. MOTHER'S MAIDEN NAME <u>Abecia Van Sant</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Walter W. DeShane</u>		Address <u>Chesapeake City</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CHRONIC NEPHRITIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>APRIL 1956</u>
--	--	---

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VARICOSE ULCERS BOTH LEGS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
---	--	---

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>19</u> p. m. <u>  </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>APRIL 4</u> , 1956, to <u>Aug 11</u> , 1957, that I last saw the deceased alive on <u>Aug 10</u> , 1957, and that death occurred at <u>6:45 A.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Henry U. Davis</u>	ADDRESS (Street, city or town, state) <u>CHESAPEAKE CITY MD</u>
DATE SIGNED <u>8/11/57</u>	
PHYSICIAN'S NAME (Type) <u>HENRY U. DAVIS M.D.</u>	

22a. BURIAL, CREMATION, REINTERMENT (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bethel Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter DuBois, Jr.</u>		ADDRESS <u>Elkton, Md</u>	24a. REC'D BY REGISTRAR DATE <u>8/16/57</u>
		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. J. Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
AUG 19 1957  
BUREAU V. S.



08418

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CECIL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CECILTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>V.</u> Last <u>EVERETT</u>		4. DATE OF DEATH Month <u>AUG.</u> Day <u>25</u> Year <u>1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 24, 1883</u>
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>CHARLES BENSON</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE COX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MR. SAMUEL EVERETT</u>		Address <u>CECILTON, MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Paralysis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Massive Cerebro-vascular Accident</u> DUE TO (c) <u>Severe Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u> <u>6 hours.</u> <u>4-5 years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>51</u> , to <u>Aug 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 25</u> , 19 <u>57</u> , and that death occurred at <u>11:00</u> M., from the causes and on the date stated above.		
ADDRESS (Street, city or town, state) <u>WALLACE OBERHAIN, MD. CECILTON, MD.</u>		DATE SIGNED <u>28 Aug 57</u>
ACTUAL SIGNATURE <u>Wallace Oberhain</u>		
PHYSICIAN'S NAME (Type) <u>—</u>		

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>AUG. 27, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MASSEY CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>MASSEY MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Bellows, Millington, MD.</u>		24. REGD. TO REGD. STAR <u>16 29 1957</u>	25. REGISTRAR'S SIGNATURE <u>J. R. Fryer</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

JUN 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
08431 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 92

08430

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, Rural</b>		c. LENGTH OF STAY IN 1b <b>12 yrs. LIFE</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.3.</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bonnie</b> Middle <b>Sue</b> Last <b>Fink</b>		4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>97 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-17-57</b>
9. AGE (in years last birthday) yrs. <b>2</b> Months <b>13</b>		IF UNDER 1 YEAR Months <b>13</b> Days <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Elkton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred Cecil Fink</b>		14. MOTHER'S MAIDEN NAME <b>Edna Marie Caldwell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Alfred C. Fink, Elkton, R.D.3. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Concussion with laceration of nostril left .</b> <b>902.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of bed when left alone</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>1.30</b> o. m. <b>830</b> 19 <b>57</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> <b>home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>		20f. (City or town) (County) (State) <b>Elkton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b> NAME (Type) <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>8-31-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept 1, 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BLAKE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BLAKE Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Henry Pappas</b> ADDRESS <b>Elkton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>9/1/57</b>	
24b. REGISTRAR'S SIGNATURE <b>J.R. Frazer</b>			

65284

RECEIVED

SEP 4 1907

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

08419

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08431

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN Td <b>2 1/2 months</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>W</b> Last <b>FREELAND</b>		4. DATE OF DEATH Month <b>8</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-1887</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>19</b> Min. <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Con. Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;NW RY</b>	
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>No Information</b>		14. MOTHER'S MAIDEN NAME <b>No Information</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Katherine Freeland, R.D. 1 Elkton, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>981X GUNSHOT WOUND OF CHEST</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>PAUL F. GUERIN</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8-3-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-5-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Chicago</b>		22d. LOCATION (City, town, or county) (State) <b>Chicago Ill.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Henry Rappin</b>		24a. REC'D BY REGISTRAR <b>8/6/57</b>	
24b. REGISTRAR'S SIGNATURE <b>HR Frazier</b>			



RECEIVED

AUG 7 1957

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08432 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 084322

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Cecil</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside of corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 4</u> c. LENGTH OF STAY IN 1b <u>all life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> <span style="float: right;">b. COUNTY <u>Cecil</u></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D. 4</u> X d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Everett</u> Middle <u>Le Roy</u> Last <u>Hall</u>				<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>13</u> Year <u>19 57</u>											
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4-30-1900</u>		<b>9. AGE</b> (In years last birthday) <u>57</u> yrs		<b>IF UNDER 1 YEAR</b> Months _____ Days _____ Hours _____ Min. _____		<b>IF UNDER 24 HRS</b> Hours _____ Min. _____			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Paper Mill</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Penna.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Wilmer J. Hall</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Tweed</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) _____				<b>16. SOCIAL SECURITY NO.</b> <u>213-05-3994</u>				<b>17. INFORMANT</b> <u>Mrs. Marie Hall</u> , <u>Elkton, Md.</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> (c), stating the underlying cause last. DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____												INTERVAL BETWEEN ONSET AND DEATH _____			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>19</u> a. m. _____ p. m. _____				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____		<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>R.C. Dodson</u> <span style="float: right;">M.D.</span>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b>			
<b>EXAMINER'S NAME (Type)</b> <u>R.C. Dodson</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<u>8-14-57</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>8-17-57</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Cherry Hill</u>				<b>22d. LOCATION</b> (City, town, or county) <u>Elkton, R.D.</u> <span style="float: right;">(State) <u>Md.</u></span>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Ray E. Hicks, Elkton, Md.</u>						<b>24a. REC'D BY REGISTRAR</b> <u>8/16/57</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>FR J. J. J.</u>					

TO DEPUTY MEDICAL EXAMINER. This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. S.

AUG : 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08420

Item 2 Bilt. 221 2-6-57 et

## CERTIFICATE OF DEATH

08433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>21 Elkton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>207 W Main</b>		e. STREET ADDRESS <b>207 W Main</b>	
3. NAME OF DECEASED (Type or print) First <b>HARRY</b> Middle <b>D.</b> Last <b>HOLSTEN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1875 March 4, 1875</b>
9. AGE (In years last birthday) <b>82</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Wilmington, Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John W. Holsten</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ann Cook</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>207 W Main St. Kena H. Holsten Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Generalized arteriosclerosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 22, 1957</b> to <b>Aug 25, 1957</b> that I last saw the deceased alive on <b>Aug 24, 1957</b> , and that death occurred at <b>2:20</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Milford H. Sprecher</b>		ADDRESS (Street, city or town, state) <b>Elkton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>MILFORD H. SPRECHER</b>		DATE SIGNED <b>Aug 27</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-28-1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Kemblesville Medt.</b>		22d. LOCATION (City, town, or county) (State) <b>Kemblesville Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Henry Pippin</b>		ADDRESS <b>Elkton Md.</b>	
24a. REC'D BY REGISTRAR <b>8/28/57</b>		24b. REGISTRAR'S SIGNATURE <b>FRS</b>	

RECEIVED

AUG 30 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 08433 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08433

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Cecil</b> Md. b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton, R.D.4</b>		c. LENGTH OF STAY IN 1b <b>36 yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Fairhill</b>		d. STREET ADDRESS <b>Fairhill</b>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Hubis</b> Last <b>Hubis</b>		4. DATE OF DEATH Month <b>8</b> Day <b>18</b> Year <b>1957</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-2-1916</b>
9. AGE (In years last birthday) <b>41</b> yrs		10. IF UNDER 1 YEAR Months <b>12</b> Days <b>18</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>R.R. Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.R.</b>	
11. BIRTHPLACE (State or foreign country) <b>Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicholas Hubis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Leano</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>716-01-8341</b>	
17. INFORMANT <b>Steve Hubis, Rising Sun, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot in abdomen ar ensiform Cartilage</b> <b>976X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>976X</b> (c), stating the underlying cause lost. DUE TO <b>976X</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>976X</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Shot self with 12 gauge shot gun.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>1:10</b> o. m. <b>8-18-57</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Elkton, R.D.4, Cecil Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>8-19-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-21-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sarps Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Elkton R.D. Cecil Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks, Elkton, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>8/21/57</b>	24b. REGISTRAR'S SIGNATURE <b>J.R. Frazer</b>

RECEIVED  
BUREAU V. S.  
1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08434

## CERTIFICATE OF DEATH

Reg. Dist. No. 98 08435

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point, Maryland</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre DeGrace, Maryland</b>		d. STREET ADDRESS <b>119 Deaver Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>PHILIP</b> Middle <b>L.</b> Last <b>KEPPINGER</b>		4. DATE OF DEATH Month <b>August</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 22, 1933</b>
9. AGE (In years last birthday) <b>24</b> yrs.		IF UNDER 1 YEAR Months <b>24</b> Days <b>4</b> Hours <b>19</b> Min. <b>57</b>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Installer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Matthew Keppinger</b>	
14. MOTHER'S MAIDEN NAME <b>Olivia Riale</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>Korean</b>	
16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records, VA Hospital, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>193X</b> IMMEDIATE CAUSE (a) <b>BRONCHIO PNEUMONIA, BILATERAL, UNRESOLVED</b> DUE TO (b) <b>BRAIN TUMOR, RIGHT PARIETAL LOBE, MALIGNANT.</b> DUE TO (c) <b>Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 To 8 Hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>441X</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 3, 1957</b> , to <b>August 4, 1957</b> , that he was deceased on <b>August 4, 1957</b> , and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. S. Ellis,</b> M.D.		DATE SIGNED <b>8-4-57</b>	
PHYSICIAN'S NAME (Type) <b>E. S. ELLIS, M.D., Acting Director, Professional Services, VA Hospital</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>8-4-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>West Nottingham</b>	22d. LOCATION (City, town, or county) (State) <b>Nottingham, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>PRINCETON &amp; SON</b>		24a. REC'D BY REGISTRAR <b>DATE 8-5-57</b>	
ADDRESS <b>Havre DeGrace, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Innocent E. ...</b>	



BUREAU V. S.

AUG 7 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 08435 CERTIFICATE OF DEATH

08436

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>Atlantic</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point,</b>				c. LENGTH OF STAY IN 1b <b>24 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. STREET ADDRESS <b>355 North Annapolis Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>J.</b> Last <b>LONERGAN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, 1906</b>	9. AGE (In years last birthday) <b>51</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____	IF UNDER 24 HRS. Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Parking Meters</b>		11. BIRTHPLACE (State or foreign country) <b>Phila., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>THOMAS E. LONERGAN</b>				14. MOTHER'S MAIDEN NAME <b>ALICE FINIGAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>150 09 7069</b>		17. INFORMANT <b>Hosp. Records, VA Hospital, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the left temporal parietal region with hemorrhage</b> DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>o. 11</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____				
21. I certify that I attended the deceased from <b>July 18, 1957</b> to <b>August 11, 1957</b> , and that death occurred at <b>5:50 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William M. Harris</b>		M.D. <b>VAH, Perry Point, Md.</b>		DATE SIGNED <b>8-12-57</b>			
PHYSICIAN'S NAME (Type) <b>WILLIAM M. HARRIS</b>		Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>8-12-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Penna.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON,</b>		ADDRESS <b>Havre DeGrace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>8-12-57</b>	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

UREAU V. S.

JUL 14 1957

RECEIVED

08436

CERTIFICATE OF DEATH

08437

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>6yrs. 3mo. 8days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1228 Blair Mills Road</b>	
3. NAME OF DECEASED (Type or print) First <b>JONAS</b> Middle <b>G.</b> Last <b>MANNES</b>		4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-30-95</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isidore Mannes</b>		14. MOTHER'S MAIDEN NAME <b>Betty Goldsmith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>220-30-6645</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Tamponade</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rupture of the heart due to infarction</b> DUE TO (c) <b>Arteriosclerotic heart disease, severe</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 - 5 minutes</b> <b>Approx. 3 weeks</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>VA 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 29</b> , 19 <b>51</b> , to <b>August 6</b> , 19 <b>57</b> , and that death occurred at <b>11:18a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William M. Harris</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>8-7-57</b>	
PHYSICIAN'S NAME (Type) <b>WILLIAM M. HARRIS</b>		Acting Director, Professional Services	
22a. BURIAL, CREMATION, or other disposal of body <b>Removal</b>	22b. DATE THEREOF <b>8-7-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Fub. Home, 4217-9th St. Wash. D.C.</b>		24a. REC'D BY REGISTRAR <b>AUG 9 1957</b>	24b. REGISTRAR'S SIGNATURE <b>James D. Hughes</b>

RECEIVED

AUG 9 1977

U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08421

Item 7 117-179 2-30-57

## CERTIFICATE OF DEATH

08438

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillside Heights, Newark Del.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 214 Brown Leaf Rd	
3. NAME OF DECEASED (Type or print) First Middle Last Ellen M. Mc Ivor		4. DATE OF DEATH Month Day Year Aug 22 19 57	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 18 78
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Your work	
11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Howe		14. MOTHER'S MAIDEN NAME Martha Brophy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Gertrude Finney		Address 214 Brownleaf Rd Hillside Hgts. Newark Del.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia - 10.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute dilatation of stomach (c) Intestinal Obstruction - Cause Undet		INTERVAL BETWEEN ONSET AND DEATH 24 hr 24 hr 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction - old			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 20 Aug. 1957, to 22 Aug. 1957, that I last saw the deceased alive on 21 Aug. 1957, and that death occurred at 1:22 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Willford Eppes		ADDRESS (Street, city or town, state) 325 E. Main St	
PHYSICIAN'S NAME (Type) Willford Eppes		DATE SIGNED 8-22-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 8-22-1957	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Philadelphia Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Henry Copping		ADDRESS Elkton Md.	
24a. REC'D BY REGISTRAR DATE 8/24/57		24b. REGISTRAR'S SIGNATURE H. J. Frazier	

BUREAU V. 1

1113 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08422

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08439

Reg. Dist. No. 92

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 24 hrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Rural Elkton, Md.	
3. NAME OF DECEASED (Type or print) First Middle Last ROBERT PHILIP MULLEN		4. DATE OF DEATH Month Day Year August 3, 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1896
9. AGE (in years last birthday) 61 yrs		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Bainbridge NTC	
11. BIRTHPLACE (State or foreign country) Cecil Co. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Dennis Mullen		14. MOTHER'S MAIDEN NAME Elizabeth Louth	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. L 212 32 4605	
17. INFORMANT Anthony F. Mullen		Address Elkton RFD #2 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug. 2, 1957, to Aug. 3, 1957, that I last saw the deceased alive on Aug. 2, 1957, and that death occurred at 1 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		ADDRESS (Street, city or town, state) 233 E. Main Street	
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr.		DATE SIGNED 8/3/57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8-6-1957	22c. NAME OF CEMETERY OR CREMATORY Catholic	22d. LOCATION (City, town, or county) (State) Nr. Elkton, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Henry Pappas		24a. REC'D BY REGISTRAR DATE 8/6/57	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE FR Frazier	



RECEIVED

AUG 7 1957

BUREAU V. S.

Reg. Dist. No. ....

08423

## INSTRUCTIONS

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The body may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be delivered for use as a burial transit permit.

VI A15C 1.55 10M

1. PLACE OF DEATH						2. USUAL RESIDENCE (Home) or OF DECEASED									
COUNTY Cecil				MARYLAND		STATE Maryland COUNTY Cecil									
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton				LENGTH OF STAY (in this place) 17 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN									
HOSPITAL OR INSTITUTION OR STREET ADDRESS 121 B. H. St.						STREET ADDRESS (If rural give location) 121 Booth, Street									
3. NAME OF DECEASED (Type or Print)						(First)		(Middle)		(Last)		4. DATE OF DEATH (Month) (Day) (Year)			
Ernest Snead												August 10 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH February 4, 1890		9. AGE last birthday 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Housing Project		11. BIRTHPLACE (State, or foreign country) Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME George Snead						14. MOTHER'S MAIDEN NAME Unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO. 217-14-8478		17. INFORMANT & ADDRESS Tichie Anna Snead									
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (A) Cardiac due to Aortic Insufficiency												3 Years			
ANTECEDENT CAUSE(S) DUE TO (B) Chronic interstitial Nephritis												5 Years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Gastritis												4 Months			
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Uremia												3 Weeks			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)				21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> M.				21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from Jan. 2, 1941, to Aug. 10, 1957, that I last saw the deceased alive on Aug. 7, 1957, and that death occurred at 1 A.M. from the causes and on the date stated above. SIGNATURE [Signature] ADDRESS (Street, city, town, state) DATE SIGNED M.D. 245 East High, St. Elkton, Md. 8/10/57															
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF 8/12/57				NAME OF CEMETERY OR CREMATORY [Name]				LOCATION (City, town, or county) (State) Elkton Md			
24. REC'D BY REGISTRAR 8/12/57				REGISTRAR'S SIGNATURE [Signature]				25. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS [Address]			

BUREAU V. S.

AUG . . . .

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08441

08437

## CERTIFICATE OF DEATH

Reg. Dist. No.

96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perryville, Rural</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Frenchtown</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Georgeanna</b> Middle <b>Thompson</b> Last <b>Thompson</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 26, 1878</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>19</b>		IF UNDER 24 HRS. Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Henry Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Anne Pennington</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Samuel C. Thompson, Perryville, Md.</b>			
17. INFORMANT <b>Samuel C. Thompson, Perryville, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>8 yrs -</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b> <b>Diabetes -</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Port Deposit, Md.</b>				20g. (County) <b>Port Deposit, Md.</b>		20h. (State) <b>Port Deposit, Md.</b>	
21. I certify that I attended the deceased from <b>Aug 25, 1957</b> to <b>Aug 25, 1957</b> , that I last saw the deceased alive on <b>Aug 25, 1957</b> , and that death occurred at <b>2:09 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Clarence I. Benson</b> M.D.				ADDRESS (Street, city or town, state) <b>Port Deposit, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Clarence I. Benson, M.D.</b>				DATE SIGNED <b>8/28/57</b>			
22a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-29-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Asbury</b>		22d. LOCATION (City, town, or county) (State) <b>Port Deposit, Md. Rural</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>				ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR <b>8/29/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Inez E. Daugherty</b>			

# CERTIFICATE OF DEATH

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. B.

SEP 3 1957

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08438

CERTIFICATE OF DEATH

Reg. Dist. No.

08442

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>			c. LENGTH OF STAY IN 1b <b>7yrs.17days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 27</b> 0354.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>4400 Washington Blvd.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>ELMER</b> Middle <b>OAKLAND</b> Last <b>TOWNSEND</b>				4. DATE OF DEATH Month <b>August</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 14, 1873</b>		9. AGE (In years last birthday) <b>84 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jacob Townsend</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW-I</b>		17. INFORMANT <b>Unknown</b>		Address <b>Hospital Records, VA Hospital, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease with cardiac insufficiency</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerosis, general - unknown</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 8th, 19 50</b> , to <b>Aug. 25th, 19 57</b> , and that death occurred at <b>8:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>8-26-57</b> ACTUAL SIGNATURE <b>E. S. Ellis</b> M.D. PHYSICIAN'S NAME (Type) <b>E. S. Ellis M.D.,</b> Actg. Director, Professional Services.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8-26-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Marion, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; CO. FUNERAL HOMES, Salisbury, Md.</b>				24a. REC'D BY REGISTRAR <b>DATE 8-26-57</b>		24b. REGISTRAR'S SIGNATURE <b>Irene E. Daugherty</b>	

1957 26 50